DEPARTMENT OF DEFENSE
NONAPPROPRIATED FUND HEALTH BENEFITS PROGRAM

Summary of Benefits

Open Choice® PPO Medical Plan

Effective January 1, 2007

Plan Provisions	Open Choice PPO Benefits Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (Out-of-Network)
Calendar Year Deductible		
★ Individual	$200	$ 600
★ Family	$600 (3 times individual)	$1,800 (3 times individual)
Out-of-Pocket Limit (the maximum amount you pay for your share of covered expenses in a calendar year. Copays, confinement fees, expenses covered at 50% and non-covered expenses do not count toward your Out-of-Pocket Limit)		
★ Individual	$3,000	$ 4,000
★ Family	$9,000 (3 times individual)	$12,000 (3 times individual)
Lifetime Maximum	Unlimited	Unlimited
Precertification Certain services require precertification. Please see your Summary Plan Description (SPD) for details.	Network physician handles	You handle; $500 penalty for failure to precertify
Preventive Care Deductible is waived for preventive care services		
★ Routine physical exam and immunizations (one per calendar year)	100%, no copay	Not covered
★ Well-child care and immunizations Birth to age 7. Please see your SPD for age and frequency schedule.	100%, no copay	Not covered
★ Routine gynecological exam including Pap test and related lab fees (one per calendar year)	100%, no copay	Not covered
★ Routine Mammogram (one per calendar year for women age 35 and over)	100%, no copay	Not covered
★ Routine prostate screening exam (one per calendar year for men age 40 and over)	100%, no copay	Not covered
★ Routine eye exam (one per calendar year)	100%, no copay	Not covered
★ Prescription eyewear - lenses, frames and contacts (in addition to Vision One® Discount Program)	100%, no copay, up to a $150 maximum benefit per person per calendar year	100%, up to a $150 maximum benefit per person per calendar year
★ Routine hearing exam (one per calendar year)	100%, no copay	Not covered
★ Hearing aids ($1,000 lifetime maximum)	100%, no copay	100%
Physician Services		
★ Office visits for treatment of illness or injury	100% after copay: $15 PCP*/ $35 specialist; no deductible	60% after deductible
★ Diagnostic lab and X-ray		
> When part of an office visit	100% (no additional copay)	60% after deductible
> Separate office visit	100% after copay: $15 PCP*/ $35 specialist	60% after deductible
> Independent facility	90% after deductible	60% after deductible
★ Maternity care office visits	100% after copay: $15 PCP*/ $35 specialist for first visit; subsequent visits are included in the delivery fee and paid at 90% after deductible	60% after deductible
★ In-office surgery	100% after copay: $15 PCP*/ $35 specialist; no deductible	60% after deductible
★ Physician hospital visits	90% after deductible	60% after deductible
★ Anesthesia	90% after deductible	60% after deductible
★ Allergy testing, serum and injections	100% after copay: $15 PCP*/ $35 specialist when part of office visit; otherwise 100% no copay, no deductible	60% after deductible
★ Second surgical opinion	100%, no copay, no deductible	100%, no deductible
* *A Primary Care Physician (PCP) can be an internist, pediatrician, family practitioner or general practitioner. A provider who does not meet this definition is considered a specialist.*		
Hospital Services		
★ Inpatient hospital room and board and ancillary services	90% after deductible plus $200 per confinement fee*	60% after deductible plus $400 per confinement fee*
★ Inpatient and outpatient surgery	90% after deductible	60% after deductible
★ Outpatient services	90% after deductible	60% after deductible
★ Pre-operative testing	90%, no deductible	60%, no deductible
★ Other hospital services	90% after deductible	60% after deductible
* *Hospital confinement fee is waived for newborns and subsequent hospital confinements for the same condition within the same calendar year.*		

DoD OC 06-0220 (9/2006)

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continued

Plan Provisions	Open Choice PPO Benefits Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (Out-of-Network)
Emergency Care		
★ Hospital emergency room	100% after $150 emergency room copay (waived if admitted); no calendar year deductible	100% after separate $150 emergency room deductible (waived if admitted); no calendar year deductible
★ Hospital emergency room for non-emergency care	50% after deductible plus $150 emergency room copay	50% after deductible plus separate $150 emergency room deductible
★ Ambulance	80% after deductible	80% after deductible
Other Health Care		
★ Convalescent facility (up to 90 days per calendar year)	90% after deductible	60% after deductible
★ Home health care (up to 90 visits per calendar year)	90% after deductible	60% after deductible
★ Private duty nursing (up to 70 eight-hour shifts per calendar year)	90% after deductible	60% after deductible
★ Hospice (inpatient and outpatient)	100%, no copay, no deductible	100%, no deductible
★ Independent lab and X-ray facilities	90% after deductible	60% after deductible
★ Voluntary sterilization	100% after $100 copay; no deductible	60% after deductible
★ Short-term rehabilitation (60-day maximum per course of treatment)	80% after deductible	80% after deductible
★ Durable medical equipment	80% after deductible	80% after deductible
★ Spinal disorder (chiropractic) (20 visits per calendar year)	100% after copay: $15 PCP/$35 specialist; no deductible	60% after deductible
★ Bariatric surgery	50% after deductible	50% after deductible
Mental Health Care*		
★ Inpatient (no maximum on number of days)	80% after deductible plus $200 inpatient per confinement fee	60% after deductible plus $400 inpatient per confinement fee
★ Outpatient (up to 45 visits per calendar year)	100% after $35 copay per visit; no deductible	60% after deductible
* *Outpatient day maximums for Mental Health and Substance Abuse are not combined. However, Preferred and Non-Preferred limits are combined.*		
Substance Abuse Treatment*		
★ Inpatient (up to 45 days per calendar year)	80% after deductible plus $200 inpatient per confinement fee	60% after deductible plus $400 per confinement fee
★ Outpatient (up to 45 visits per calendar year)	100% after $35 copay per visit; no deductible	60% after deductible
* *Outpatient day maximums for Mental Health and Substance Abuse are not combined. However, Preferred and Non-Preferred limits are combined.*		
Prescription Drug Benefits		
Participating Retail Pharmacy Program (up to a 30-day supply purchased at a local participating pharmacy)	*Participating Pharmacy*	*Non-Participating Pharmacy*
★ Generic drugs	100% after $10 copay	Not covered
★ Formulary brand-name drugs	100% after $25 copay	Not covered
★ Non-formulary brand-name drugs	100% after $35 copay	Not covered
Prescriptions Purchased Overseas		
★ Generic drugs	Not applicable	100% after deductible
★ Brand-name drugs	Not applicable	80% after deductible
Mail-Order Service (up to a 90-day supply)		
★ Generic drugs	100% after $20 copay	Not applicable
★ Formulary brand-name drugs	100% after $40 copay	Not applicable
★ Non-formulary brand-name drugs	100% after $60 copay	Not applicable

Covered dependents who live outside the Open Choice network area will receive the Traditional Choice® indemnity plan level of benefits. Please see your Human Resources Representative for details. This chart displays only a general description of your benefits under the DoD NAF HBP. Should there be a conflict between the benefits shown on the chart and those in the Summary Plan Description (SPD), the terms of the SPD will be used to determine coverages and benefits.